**BYLAWS AND OPERATING PROCEDURES**

**WEST CENTRAL FLORIDA RYAN WHITE CARE COUNCIL**

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I. PREFACE

The West Central Florida Ryan White Care Council (Care Council) is the Ryan White HIV Planning Council for the Tampa-St. Petersburg Eligible Metropolitan Area (EMA) and covers the following eight counties within its total service area: Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk.

In order to function as effectively and efficiently as possible, the Part A HIV Health Services Planning Council and the Part B HIV Comprehensive AIDS Resources Emergency (CARE) Act Consortium voted on March 17, 1998, to merge both bodies into a single body. This merging allows for greater, more cost-effective coordination in program planning, implementation and evaluation. Within this single body, it is essential to recognize the differing authority and autonomy within a Planning Council versus a Part B Consortium. For this reason, these Bylaws and Operating Procedures are organized to combine similar responsibilities while ensuring any legislated distinctions are recognized and represented.

II. DESIGNATION AND PURPOSE

A. Federal Designation

The Care Council shall conduct its activities in accordance with the provisions, interpretations and recommendations of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, its primary funding source, and with all applicable local, state, and federal laws and regulations.

B. Purpose

The Care Council in keeping with the Ryan White CARE Act of 1990, as amended, will:

1. Develop and implement needs assessment activities;

2. Establish priorities and allocate funds;

3. Assess the efficiency of the administrative mechanism of the Recipient;

4. Assess the effectiveness of the services supported by the Act funds;

5. Develop and adopt a comprehensive plan;

6. Participate in the development of the Statewide Coordinated Statement of Need (SCSN).

III. LOCAL IMPLEMENTATION OF THE RYAN WHITE PROGRAM

1. Part A- Relationship with Recipient

The Hillsborough County Board of County Commissioners is designated as the Chief Elected Official (CEO) of the EMA. Through the County Administrator, the CEO designated the Hillsborough Health Care Services Department to administer the Part A grant. The CEO is ultimately responsible for administering all aspects of the Ryan White Program in the EMA and ensuring that all legal requirements are met. The Hillsborough County Health Care Services Department is the Part A Recipient and manages the day-to-day operations of the Part A program.

*Recipient* responsibilities include:

1. procurement of services;

2. monitoring contracts;

3. submission of grant applications;

4. compliance with conditions of award;

5. meeting reporting requirements;

6. communicating the results of procurement to the Care Council, defining a process that outlines how procurement results are to be communicated, and if there are differences between priorities identified by the Care Council and the services funded by the *Recipient*, how differences will be resolved; and

7. developing Recipient grievance procedures.

*Recipient* and Care Council shared responsibilities include:

1. conducting a comprehensive needs assessment;

2. developing an open nominations process;

3. developing integrated/comprehensive plan; and

4. development of service standards.

The Care Council’s responsibilities to the Recipient include:

1. establishing annual priorities and the best way to meet such priorities;
2. allocation and reallocation of resources, according to service priorities and with consideration to other available funding streams;
3. receive and review expenditure data;
4. understanding the delineation between the Recipient’s responsibility for procurement of services through contractors and the Care Council’s responsibility for prioritization and allocation of funds to services; and

5. assessment of the efficiency of the administrative mechanism.

B. Part B - Relationship with State and Local Lead Agency

The State of Florida Department of Health (FDOH) was designated by Lawton Chiles as the agency responsible for administering Part B funds for the State of Florida. The FDOH designated the Division of Disease Control and Health Protection, Bureau of Communicable Diseases, HIV/AIDS Section to administer the State Part B program. The FDOH HIV/AIDS Section designated the Florida Department of Health in Pinellas County as the Part B Lead Agency.

State responsibilities include, but are not limited to:

The State is responsible for developing and submitting a State application which contains agreements, assurances and information the Secretary deems necessary to carry out this part. The application must include:

1. detailed description of services provided in the preceding year;
2. description of the types of programs funded by the State;
3. an accounting of the amount of funds the State has expended for such programs;
4. report on number of individuals to be served by the grant;
5. report on demographic data on the population to be served;
6. report on average cost of providing each category of services and the extent to which such cost is paid by third party payors;
7. report on aggregate amounts expended for each such category of services;
8. a comprehensive plan for the organization and delivery of HIV services;
9. a detailed description of how the allocation and utilization of resources are consistent with the Statewide coordinated statement of need; and
10. assurances that the agency will periodically convene a meeting of individuals for the purpose of developing a Statewide coordinated statement of need.

Lead Agency responsibilities include:

The Lead Agencies are designated by the local consortia as being responsible for the administrative, fiscal and other responsibilities related to the Part B awards for the respective geographic regions within the state. The lead agency acts as the fiscal conduit and data coordinator for all funded providers within the consortium.

Care Council responsibilities to the State include:

The Care Council acts in an advisory capacity to the state for the purpose of planning and prioritizing Part B funds as well as providing a forum for the community living with, vulnerable to, and impacted by HIV, providers and others. The consortium exists to support and facilitate the provisions of coordinated, comprehensive health and support services to people living with HIV/AIDS.

Care Council responsibilities to the Lead Agency include:

1. Conduct needs assessment

2. Plan and set service priorities

3. Promote coordination and integration of community resources

4. Assure the provision of comprehensive outpatient health and support services

5. Evaluate the success and cost effectiveness of the consortium in responding to service needs

IV. MEMBERSHIP AND APPOINTMENT PROCESS

A. Legal Requirements

1. Members of the West Central Florida Ryan White Care Council meet very strict membership criteria. In addition, the Care Council must have a documented membership and nominations process which is followed. The requirements of the Care Council include the representation of health care and support service providers and community-based organizations within the service area. County represented is determined by the member’s residence or place of employment.

a. The Care Council shall reflect in its composition the demographics of the HIV epidemic in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and sub-populations. Nominations for membership on the Council shall be identified through an open process and candidates shall be selected based upon locally delineated and publicized criteria. Such criteria shall include a conflict of interest standard that is in accordance with section V.

b. The Care Council shall include representatives of the following groups, as required in the Ryan White legislation:

1. **health care providers, including federally qualified health centers**: members must receive financial remuneration from or serve as an officer of an agency that provides direct health care, or the member must be a direct health care provider (i.e., physician, dentist, nurse, physician’s assistant, etc.).
2. **community based organizations serving affected populations and AIDS service organizations**: members must receive financial remuneration from or serve as an officer of a community-based organization or AIDS service organization that provides services to people living with HIV or AIDS.
3. **social service providers, including housing and homeless services**: members must receive financial remuneration from or be an officer of an agency that provides social services.
4. **mental health providers**: members must receive financial remuneration from or be an officer of an agency that provides mental health services, or the member must be a direct mental health care provider (i.e., counselor, social worker, etc.).
5. **substance misuse providers**: members must receive financial remuneration from or be an officer of an agency that provides substance misuse services, or the member must be a direct substance misuse health care provider (i.e. counselor, social worker, etc.)
6. **local public health agencies**: members must be employed by the Department of Children and Families or the Health Department in the EMA.
7. **hospital planning agencies or health care planning agencies**: members must receive financial remuneration from or serve as an officer of an agency that is involved in hospital or health care planning within the EMA.
8. **affected communities**, including people living with HIV or AIDS and historically underserved groups and sub-populations
9. **non-elected community leaders**: members cannot be an elected official, but must be an individual within the EMA who is recognized by members of a specific community to represent the viewpoints of people living with HIV or AIDS within that community.
10. **state government** (including the State Medicaid agency and the agency administering the program under part B)
11. **Part B**: members must be directly involved with a Part B grant
12. **Part C**: members must be directly involved with a Part C grant
13. **Part D**: members must work or be directly involved with women, children, youth, and families living with HIV.
14. **Recipient under Federal HIV programs**, including HIV prevention service providers, AIDS Education and Training Center (AETC), Housing Opportunities for People with AIDS (HOPWA), Special Projects of National Significance (SPNS), Dental Program
15. **Formerly incarcerated**: representatives of individuals who formerly were federal, state or local prisoners, who were released from the custody of the penal system during the preceding three years, and had HIV on the date on which the individuals were released

Not less than 33% of the Care Council shall be individuals who are living with HIV, receiving Ryan White services, and are not officers, employees or consultants to any entity that receives amounts from such a Ryan White grant, and do not represent any such entity, and reflect the demographics of the population of individuals living with HIV. An individual shall be considered to be receiving such services if the individual is a parent of, or a caregiver for, a minor child who is receiving such services.

B. Membership Category Monitoring

The membership of the Care Council must reflect the demographic composition of the HIV epidemic of the Eligible Metropolitan Area (EMA). Non-EMA counties that have ten percent or more of the Total Service Area’s (TSA) PLWH population will have two representatives on the Care Council. In addition, the Care Council shall include representatives of a wide variety of categories as referenced in paragraph (2). To ensure that the Care Council meets the membership requirements of the law, the Care Council administrative staff will monitor the membership of the Care Council as follows:

1. The staff will determine and specify the required representation groups and categories of the Care Council membership (including requirements from the legislation, reflectiveness of the epidemic, and geographic areas of the total service area). This information will be provided to HRSA and the Recipient’s office in matrix form. This matrix will include the following information:

a. Category: This column reflects the type of membership category an individual can represent. This includes not only the categories listed under paragraph (2), but demographic categories as well.

b. Required Percentage: Of the entire membership, this column reflects the percentage of members required in each category.

c. Number of Members Required: This column reflects the same information as the required percentage, but translated into total required members rather than percentage.

d. Actual Percentage: Of the entire membership, this column represents the percentage of members that are currently (or actually) in each category.

e. Actual Number of Members: This column reflects the same information as the actual percentage of member column, but translated into total actual members rather than percentage of actual members.

f. What We Need: This column reflects the difference between the number of members required column and the actual member column.

2. A variety of other membership reports are kept internally by staff to monitor membership.

3. The staff will monitor this listing closely to determine where fulfillment of membership categories is lacking or nonexistent. Please see Section C below, Membership Openings, for the process of filling lacking or nonexistent membership categories.

C. Membership Openings

1. There will be two different types of membership openings: a) through annual membership expirations, and b) through ongoing openings created by resignations, illness, excessive absences, and other factors

a. Annual Membership Expirations: Per the Care Council Operating Procedures, members will serve three-year terms. A maximum of six consecutive years of membership may be served. Following two consecutive terms of service, a member must sit out a full year before returning to the Care Council as a voting member. If there is no qualified new applicant for a HRSA-mandated category an exception can be made and a member can serve an additional full term.

b. Ongoing Openings: As members resign or are released from membership, the membership categories they occupied will be reviewed by the Membership Committee.

2. Process for filling openings created by annual membership term expirations and ongoing openings.

a. The administrative staff and the Membership Committee will review the openings to determine what membership categories will be vacated.

b. Specific targeted recruitment will be implemented so as to ensure applications are received for those categories which will be left vacant.

D. Membership Applications

1. Applications will be provided to all interested parties. If an individual has applied in the past but was not appointed, they must reapply in order to be considered for current membership. Applications will specify the required representation groups and categories of the Care Council membership, open-ended questions to capture information about nominee experience and background, and the scoring criteria for the application. This application will be sent to interested individuals with a brochure identifying the federal designation of the Care Council, its roles and responsibilities, and other pertinent information.

2. A Conflict of Interest Form and a Confidentiality Form will be attached to the application. If nominees do not fill out the application section pertaining to conflict of interest or confidentiality, their application will NOT be reviewed nor considered for membership.

3. Completed applications will be submitted to the Care Council administrative staff.

4. Applications will be reviewed to determine if other members of an applicant’s agency, as it applies to conflict of interest, already sit on the Care Council. Per the Bylaws and Operating Procedures, no two members of one agency may sit on the Care Council, unless the Council and/or staff has determined that the inclusion of an individual who represents the same agency as an existing member is integral to the Care Council planning and decision-making process. If it is determined that two individuals from one agency will sit on the Care Council, one must be a PLWH.

5. Applications will be reviewed by the Care Council staff for completeness. If an application is not complete, the staff will contact the individual for the missing information and/or return the application to the prospective member for completion.

6. Applications will be reviewed by the Care Council staff to determine if the openings created can be filled with the existing applications. If the existing applications have been reviewed and it is determined that the critical categories will be left unrepresented, staff and the Membership Committee must take additional measures to target and recruit applications from those categories.

7. Once Care Council staff has determined that an applicant is eligible for voting membership on the Care Council, staff will forward the applicant’s contact information to a member of the Membership Committee for interview. The Membership Committee member will conduct a brief interview with the applicant, based on interview questions determined by the Committee, and send an interview transcript back to Care Council staff to be presented at the next Membership Committee meeting.

E. Membership Elections

1. The Membership Committee will evaluate and score the applications, using the criteria and points identified on the application and scoring sheets provided. Scoring sheets will reflect the majority of points given for the open-ended questions to capture vital information.

2. Applicant’s county representation will be determined by county of residence for individuals representing the affected community; county in which the agency has the largest number of clients if agency representation; and district representation if a governmental representative. Membership Committee members will review each application and score according to publicized and explained criteria. Committee member scores for each application are then added to achieve a “grand total” score for that application. A minimum passing score will be required for the applicant to be considered as eligible for membership. A “passing score” will be considered a score of 70% of the maximum points allotted for the application.

3. The Membership Committee must review their membership prior to each application evaluation to ensure representativeness and impartiality. If any member is in violation of the following criteria, they must recuse themselves from scoring and voting.

a. No Membership Committee member may vote on their own application.

b. No Membership Committee member can be employed or serve as an officer of an agency which is represented by an applicant.

4. If there is no competition among the slots available (the number of applications equals the number of openings) and the existing applications will allow the Care Council to fill the required representation of categories (including legislatively mandated categories, reflectiveness of the epidemic, and geographic areas from the EMA), the committee may select all applications to recommend to the full Care Council for election and submission to the Hillsborough County Board of County Commissioners for approval and appointment.

5. If there is competition among the slots available and the existing applications allow the Care Council to fulfill the required representation of categories, the committee may select those applications which scored highest and place them into the respective categories, ensuring that no category has been left unrepresented.

6. Once the nominees have been selected, the MembershipCommittee will recommend them to the Care Council for approval.

7. New members must be present at the Care Council meeting during the month in which their membership goes before the Care Council, with quorum present, in order to be considered for approval. If the new member is not in attendance, the motion for approval of new voting or associate membership will be tabled until he/she attends a Care Council meeting. Once voted in, the new membership term and all voting privileges will begin.

8. Special consideration will be made for PLWHs and members of underserved populations so that the Care Council composition is as comparable as possible to the demographics of the total service area.

9. The list of recommended members approved by the Care Council will then be forwarded to Hillsborough County, through the County’s Administrative Agency, which is the final appointment authority. Those completing their terms may be reappointed through the normal nomination and approval process as outlined above.

10. The target number of Care Council voting members is thirty (30) and may range from 20 to 40. All categorical representations mandated by the Part A legislation, HRSA guidance, State requirements, and these Bylaws and Operating Procedures will be maintained. If any conflicts arise among the above documents, the Part A legislation will take precedence.

F. Membership Training/Orientation

1. Upon approval of the Care Council, applicants will be notified that they have been recommended to the Hillsborough County Board of County Commissioners for formal appointment. Once appointed, new members will also be required to fill out an alternate selection form, identifying an individual that will attend meetings and vote on their behalf. In the event that the member cannot attend, their alternate must attend otherwise their absences is counted as such. This is necessary to ensure that quorum is met so that the Care Council may conduct business.

2. Once the Care Council has approved a new member they will be formally recognized at the Care Council meeting. New members will receive a membership manual which includes: the Ryan White Program, Member Roles and Responsibilities, Care Council Bylaws and Operating Procedures (which will include the nomination process), a handout on the Florida Sunshine Law~~s~~, and a contact list which includes information for the Recipient, Lead Agency, and Care Council Support staff. In addition, a mandatory orientation will be held for all new members. All new members are required to attend an orientation within ninety (90) days of Care Council membership approval or Care Council membership will be considered for termination. Additional leadership trainings will be conducted by the Membership Committee and held for members on an ongoing basis. Topics include conflict of interest, grievances, member roles and responsibilities, comprehensive planning, needs assessment, and other pertinent topics.

G. Changes in Membership Status

Members are individuals appointed by the Hillsborough County Board of County Commissioners. The HRSA membership category that a member represents at the time of application as well as their geographical, gender, and racial/ethnic categories are tracked in order to fulfill the Care Council’s mandated membership requirement to mirror demographics of thepopulation living with HIV within the EMA. Thus, a member represents a very specific set of criteria.

It is important to note that it is the category that is represented on the Care Council, not the agency. Therefore, if a member resigns from an agency, that agency will not be permitted to automatically assume the seat on the Care Council. A representative of that agency may apply for membership and pursue membership through the membership and nominations process.

H. Membership Responsibility

Members of the Care Council have the following responsibilities:

* + - 1. act as an objective community planner in the best interest of the entire HIV/AIDS community;
      2. become familiar with and practice the roles and responsibilities of a Care Council member;
      3. may chair one Care Council committee, subcommittee, work group, and/or ad-hoc committee;
      4. attend and actively participate in monthly Care Council meetings and appropriate committee meetings, or send their alternate when they are unable to be present;
      5. attend the new member orientation;
      6. attend biannual leadership trainings;
      7. be prepared for meetings, discussions and votes by reading distributed material prior to meetings;
      8. participate in objective discussion and voting regarding Care Council issues and agenda items;
      9. refrain from voting or participating in discussion when potential conflict of interest arises;
      10. support final majority Care Council votes regardless of individual vote; ~~and~~
      11. be an active member of at least one committee or work group; and
      12. treat fellow members, staff, and guests with respect and refrain from using language that is threatening, culturally insensitive, or intending to be hurtful.

I. Chairperson Selection and Responsibility

1. Selection and Term: The Chairperson of the Care Council is appointed by and serves at the discretion of the CEO of the Part A EMA, who is the Chairperson of the BOCC, acting in consort with the other BOCC members. The Care Council may not be chaired solely by an employee of the recipient. The Membership Committee Chairperson, in coordination with the Care Council Administrator, will present a slate of nominees to the Care Council at least thirty (30) days before elections; which are normally in August. The day the slate is presented, additional nominations may be taken from the floor. The Care Council will vote on the nominees and forward its selection for the Care Council Chairperson to the BOCC through the Administrative Agency. The recommendation will then be presented to the BOCC/CEO as an agenda item initiated by the Health Care Services Department. If approved, the appointed Chairperson will serve for a two-year term. The term will normally begin on or about September 1. The Care Council Chairperson may be reelected and approved for one additional consecutive two-year term.

2. Duties and Responsibilities: The primary responsibility of the Chairperson is to ensure the Care Council responsibilities mandated by HRSA and the Ryan White legislation are accomplished. The Chairperson will also preside over all Care Council meetings, appoint committee chairpersons and committee members with the concurrence of the Care Council when requested, ensure projects and tasks assigned to the Care Council and Care Council Administrator are in accordance with the mandated duties of the Care Council, and work with the Part A Recipient and the Part B Lead Agency, the State, the Care Council Administrator and staff to fulfill all necessary and appropriate Part A and Part B requirements on behalf of individuals living with HIV and their families.

3. Expectations and Removal: The appointed Chairperson is expected to conduct the business of the Care Council with impartiality, fairness, and dignity. The Chairperson is expected to attend all meetings of the Care Council and be available for consultation with Recipient and Lead Agency representatives, Federal Grantor representatives, State representatives, the Care Council Administrator, members of the Care Council, and others, as necessary, to fulfill the mandated responsibilities of the Care Council. In addition, the Care Council Chairperson should have the leadership qualities necessary to make a responsible, committed Chairperson, as well as the skills and knowledge necessary to make an effective Chairperson. If the Chairperson is a provider, this individual should have the ability to remain neutral and impartial in acting as Chairperson, by objectively focusing on the purpose of the existence of the Care Council, which is to act in the best interest of the client and the entire HIV community. This individual’s participation as Chairperson should make a value-added contribution to the Ryan White Part A and B Care Council. The Chairperson casts no vote on Council matters, except in the event of a tie, in which case their vote serves at the deciding vote. Removal for cause may be recommended to the BOCC by a two-thirds vote of the Care Council membership during a scheduled Care Council meeting, with the item placed on the agenda in advance, recorded in the meeting minutes, and delivered to the Recipient in writing by the Care Council Administrator explaining the reasons for the recommendation.

J. Vice Chairperson

The Care Council will recommend a Vice Chairperson for appointment by Hillsborough County through the Recipient, based on the results of the same Care Council nomination/election process outlined for the Chairperson. Selection and appointment will be for a two-year term. Should the Chairperson be absent from any scheduled meeting, the Vice Chairperson will serve as Chairperson. Should the Chairperson resign or be removed by BOCC action, the Vice Chairperson will assume the duties of the Chairperson until the end of the unexpired term. A Vice Chairperson will be elected following procedures specified in the Care Council bylaws at the next Care Council meeting. The Vice Chairperson is subject to the same expectations and removal requirements as the Chairperson.

K. Committees and Work Groups

1. The Care Council may establish committees and work groups as required to accomplish its Part A and Part B mandated duties and responsibilities and to perform other necessary work for the good of the Care Council and affected communities.

2. The standing committees and work groups of the Care Council shall include (but are not limited to):

a. Planning and Evaluation

b. Membership and Community Outreach

c. Standards, Issues and Operations (SIOC)

d. Resource Prioritization and Allocation Recommendations

(RPARC)

e. Women, Infants, Children, Youth and Families (WICYF)

f. Health Services Advisory Committee

1. Committee Requirements

Each committee, subcommittee, and ad-hoc committee must be co-chaired by a voting member of the Care Council. Each committee is responsible for the development and implementation of an annual work plan in accordance with the adopted Care Council Comprehensive Plan. The Chair and Co-Chair will be invited to participate in a leadership training.

Each chair and co-chair must be members of the committee and will be elected by a quorum of the committee at a scheduled meeting with advance notice of the agenda. The role of the chair is: 1) to preside over all meetings of the committee; and 2) to ensure all responsibilities of the committee are fulfilled. The role of co-chair is: 1) to ensure community participation and leadership in the committee; 2) to assist the chair in carrying out the responsibilities of the committee; and 3) to ensure continuity in committee leadership by carrying out committee chair activities in the temporary absence of the chair.

Ideally, all committees of the Care Council should be composed of a minimum of 33% people living with HIV and receiving Ryan White services. Each committee, subcommittee and ad-hoc committee should, when possible, be co-chaired by a person living with HIV.

All newly appointed Care Council members in attendance at the first committee meeting following their Care Council appointment will be offered the option of becoming voting members of that committee. Subsequently, unless otherwise specified in the descriptions below, any member of the community may become a voting member of a committee after attending two committee meetings and requesting through the Chair of that committee that they be added to the listing of committee members. If a committee member misses three or more meetings, they may be removed from the roll call of that committee. Members are eligible to join the committee again on the third meeting that they attend after removal.

1. Work Group Requirements

Work groups may be established for the purpose of working on a particular project or discussing special interests. Work groups do not have formal voting membership but are made up of Care Council members, community members, and guests. Work groups may choose to select co-chairs or rotate through the membership taking turns leading meetings. Whenever possible, work groups should be co-chaired by a person living with HIV. Each work group must follow an established work plan in accordance with the Care Council Comprehensive Plan.

7. Committee and Work Group Descriptions, Requirements and Status

a. Planning and Evaluation

This committee provides input to staff regarding components to be included in the annual needs assessment; ensures that the needs assessment is comprehensive and reflects the components required by the legislation, HRSA and the State; and ensures that appropriate populations are represented in data collection within time and resource constraints. This committee is responsible for developing a comprehensive, community plan for the organization and delivery of HIV/AIDS services that is compatible with existing state or local plans regarding the provision of health services to individuals with HIV. The committee also develops an implementation plan for the goals, objectives, strategies and evaluations which result from the final plan.

This committee develops program evaluation requirements based on Federal legislature, HRSA guidance and the Comprehensive Plan program goals and objectives. In addition, the committee ensures that requirements are met and reviews results of program evaluation. It revises program evaluation as needed and seeks to include key indicators or evaluation criteria to measure the extent to which pre-determined goals have been achieved, including cost and effectiveness measures.

1. Special Committee Requirements: None
2. Subcommittees: None

b. Membership and Community Outreach

This committee is responsible for understanding the membership process; ensuring that the Care Council adheres to strict legislative membership requirements; ensuring membership application and selection process is effective and administered appropriately; advises governing body in membership issues; works with staff in ensuring appropriate member recruitment, training and orientation, and conducting community outreach. The Membership and Community Outreach Committee is responsible for reviewing and scoring all membership applications. In conducting community outreach, the committee seeks to provide opportunities for PLWH in all TSA counties to participate in the Care Council’s planning and decision-making process, regardless of membership status. This committee is also responsible for the nomination and election process of the Chairperson and Vice Chairperson.

1. Special Committee Requirements: None
2. Subcommittees: None

c. Standards, Issues and Operations (SIOC)

This committee provides monitoring and oversight for the Council. It develops systems for process review; identifies emerging issues for referral to appropriate committees, and continuously reviews the strategic plan to assure compliance with Council goals and objectives. SIOC also identifies, develops and organizes grievance policy and procedures, and as necessary, resolves or recommends means of resolution to the Council.

The SIOC may be convened by one of the following: The Council Chairperson/Vice-Chairperson, the council Administrator, or a majority of voting Council members. The Vice Chairperson will serve as the Chair of SIOC. Decisions resulting from a vote of the committee are final. The Chair of SIOC will not vote, unless in the event of a tie.

Issues which may be addressed by this committee may include: conflict of interest, excessive member absences or assessing the performance of the Chair or Vice-Chair and then developing recommendations to the full Council concerning possible removal. SIOC may also convene to act on behalf of the Council to respond to emergency Part A or B program or fiscal developments (from Federal, State or local government); to provide time-sensitive, unscheduled program reports for agencies or to respond to provider emergencies requiring immediate service decisions.

The SIOC will not change service category priorities established by the Council as the basis for allocating funds. Nor may it amend the Bylaws, make decisions contrary to the Bylaws or change the Comprehensive Plan’s goals or objectives unless approved to do so by the Council.

A quorum of five members, inclusive of the Chair or Vice-Chair, must be present to convene the SIOC. The composition of the SIOC is as follows:

Chairs of these committees: Planning and Evaluation, Membership and Community Outreach, RPARC, and Health Services Advisory.

One representative of the Women, Infants, Children, Youth, and Families Work Group.

The Council Chairperson and/or Vice-Chairperson The Council Vice Chairperson is Chair of SIOC and may only vote in the event of a tie.

Two members of the Council representing affected communities. These may be voting or non-voting members.

Other individuals deemed integral to the discussion-at-hand may be called upon to serve ex-officio, as non-voting members.

(1) Special Committee Requirements: In addition to those listed above, for issues related to funding prioritization and allocation, no member may be a Part A or B provider. In the case where a committee chair is a provider, the co-chair will be designated as the member of the SIOC for that particular issue.

(2) Subcommittees: None

d. Resource Prioritization and Allocation Recommendations Committee (RPARC)

This committee is responsible for developing recommendations for the Part A and B funding prioritization and allocation process. They work in close coordination with staff to assure that this process reflects the findings of the needs assessment. The recommendations are then brought to the Council for approval and presented to the Recipient.

The committee also meets at various times throughout the year to re-allocate funds. The committee may also be called on to participate in SIOC issue discussions, which concern funding.

(1) Special Committee Requirements: Each Part A and B agency will be limited to one voting representative. If it is determined that two individuals from one agency will sit on the RPARC, one must be a PLWH.

(2) Subcommittees: None

e. Women, Infants, Children, Youth and Families (WICYF) Work Group

This work group works to ensure the active and effective participation of women and those who represent infants, children, youth, and families in the planning and decision-making process of the Council. To accomplish this, the work group will carefully consider and seek ways to ensure clients’ retention in the core medical services, with emphasis on women-centered primary care, and to eliminate or reduce barriers to care (e.g., transportation), to involve appropriate providers, to continuously identify individuals who are under served or not served and to retain these clients in the continuum of care. Finally, the work group acts as liaison between planning and service provision by working to ensure access and to eliminate barriers to services for women, infants, children, youth, and families.

1. Special Work Group Requirements: None
2. Subcommittees: None

f. Health Services Advisory

This committee serves in an advisory capacity to the Council on issues related to primary care, dental care, medications, new treatments, adherence and other clinical issues related to the maintenance and improvement of health. The committee also serves as the Local Pharmaceutical Assistance Program (LPAP) advisory committee.

1. Special Committee Requirements: This committee should include, but is not limited to, health and medical professionals and providers with diverse areas of expertise.
2. Subcommittees: None

L. Associate Members

The Care Council may appoint Associate Members to the Care Council who will not be considered in complying with the HRSA requirements for membership composition. These members will be required to regularly attend a Committee meeting and will be invited to attend Care Council meetings and retreats. The Associate Members may serve as a pool of alternates for voting members to designate as an alternate. Associate Members will only vote when serving as an alternate for a voting member.

Associate Member applicants will follow the same application process as a regular member.

V. CONFLICT OF INTEREST

1. Definition
2. Per the Ryan White HIV/AIDS Program Part A Manual,

*“Conflict of interest can be defined as an actual or perceived interest in an action that will result—or has the appearance of resulting—in personal, organizational, or professional gain. To illustrate, conflict of interest occurs when a planning council member has a monetary, personal, or professional interest in a planning council decision or vote. Any group making funding decisions for a Ryan White program should be free from conflicts of interest.”*

B. From the law (Section 2602(b)(5)):

1. The Care Council may not be directly involved in the administration of a grant (under Section 2601(a) - Part A grants to eligible metropolitan areas). The Care Council may not designate (or otherwise be involved in the selection of) particular entities as recipients of any amounts provided in the grant.

2. An individual may serve on the Care Council only if the individual agrees that if the individual has a financial interest in an entity, if the individual is an employee of a public or private entity, or if the individual is a member of a public or private organization, and such entity or organization is seeking amounts from a grant under Section 2601(a), the individual will not, with respect to the purpose for which the entity seeks such amounts, participate (directly or in an advisory capacity) in the process of selecting entities to receive such amounts for such purpose.

B. All Care Council members must complete and sign, as part of the application process and prior to appointment to the Council, a Conflict of Interest Disclosure Form. This disclosure form certifies the Care Council member has read, understands and supports the conflict of interest objectives of these Bylaws and Operating Procedures. In addition, all Care Council members shall list all the organizations with which they and/or family members are currently, or have been within the past 12 months, in a staff, consultant, volunteer, officer, board member, or advisor capacity which has received, may seek, or is eligible for funding under Part A or Part B of the Ryan White Program. In addition, clients of an organization which has received, may seek, or is eligible for Part A or Part B funding may optionally disclose any and all organizations of which they are a client.

C. The goal of the Conflict of Interest Disclosure is to reduce to the absolute minimum the potential for either actual or perceived conflicts of interests in deliberations, votes, or any other activities related to Care Council responsibilities. It also expresses to the greatest extent possible the willingness to leave the special interests of their particular agency behind during Council deliberations and agreement to act only on behalf of the broadly affected HIV community. Council members also agree to base all service priority recommendations and decisions on client needs or gaps in service on their best judgment using the approved Comprehensive Plan for a Continuum of Care and ongoing needs assessment process as the primary guides.

D. Any member not completing a conflict of interest statement within thirty (30) days of its receipt will be contacted once by Care Council staff. If a signed disclosure form is not provided within ten (10) days of receipt of said letter, the member shall be contacted to determine if there are extenuating circumstances which temporarily prevented them from returning a signed conflict of interest statement. If there are none, the member will be deemed in violation of Care Council Bylaws and Operating Procedures and their membership will be considered for termination. If terminated, the Membership Committee will be notified of the vacancy.

E. To avoid potential conflicts of interest, no two members may represent (receive financial remuneration from or serve as an officer of) the same organization unless the Council and/or staff has determined that the inclusion of an individual who represents the same agency as an existing member is integral to the Care Council planning and decision-making process. If it is determined that two individuals from one agency will sit on the Care Council, then no more than two individuals from one agency will be allowed and one individual must be a PLWH.

A conflict of interest matrix will be developed by staff, which will include a list of members and their agency affiliations. Questions about conflicts of interest for any individual Council member can be raised during any meeting. If questions remain regarding a conflict following discussion, the Chairperson will ask for a Council vote as to whether the member in question will have voting privileges on the issue in question. Specific allegations of deliberate conflict of interest regarding any activities related to the Part A or Part B program will be reviewed by the SIOC, presented to the Care Council, and referred to the appropriate county department for resolution in accordance with current rules and regulations.

VI. MEETINGS/ATTENDANCE

A. The Council will meet at least every two months to fulfill the Care Council’s mandated duties or to assist in other HIV program-related tasks. Meetings are open and non-members are welcome, but are not allowed to vote. A transcript of minutes, certified by the chair of the Care Council shall be made available for public inspection within two weeks following each Council meeting. The minutes shall contain a listing of those present; a description of matters discussed and conclusions and/or actions reached; and copies of all reports received, issued or approved by the Care Council. Minutes will be considered for formal adoption by the Care Council at its next regularly scheduled meeting.

B. Each member must designate, in writing, a voting alternate. The alternate must be designated prior to the meeting at which the alternate will substitute for the member. The designated alternate may vote only in the member’s absence. If the member decides to change alternates, he or she must submit a new name in writing.

C. Staff will keep track of absences of Care Council members at all meetings and report cumulative attendance status as needed. Attendance of the alternate in place of the member for up to three meetings will not constitute a member absence. A member cannot send an alternate more than three times a year; an alternate may not be sent for member orientation or member trainings. Three total absences by the member at regularly scheduled meetings within any 12 month period will result in a review of the member’s membership. The Council Chairperson or staff will send a letter electronically inquiring as to the reason for non-attendance and requesting the member to attend the next scheduled meeting. An absence at this meeting is considered sufficient grounds for provisional removal and subsequent replacement recommendation by the Membership Committee to the full Care Council for a vote to retain or dismiss the member. Accepted excused absences will be considered for the following: illness/hospitalization of member, death in the immediate family of the member, jury duty or subpoena. Exemptions may be granted by the Care Council Chair under special circumstances (i.e. if a member is on official Care Council business, such as at a meeting and conference on the Care Council’s behalf).

D. A quorum shall be considered present with a 33% + 1 person of the appointed Care Council members in attendance in-person. For hybrid meetings (meetings that include both in-person and virtual participation), members in attendance virtually will not be counted towards quorum. Once an in-person quorum is achieved, members attending virtually may still cast votes. The number of Care Council members shall be the number of current members as of the day of the meeting.

VII. VOTING PROCEDURES

1. All officially appointed members of the Care Council may vote on any issue brought before the body, unless it has been determined that the member is in conflict of interest with the subject vote (see section V, E). Each member will be allowed to cast only one vote. Alternates designated in writing by the member, prior to the meeting at which the alternate will substitute for the member, shall cast the absent member’s vote.

B. Any vote taken by the Care Council where the majority of votes cast equals or exceeds 50% +1 shall be considered action taken. All votes will be hand votes, unless there are greater than two dissenting votes. In that case, a roll call vote will be taken. Roll call votes are required for allocation and re-allocation of funding. Voting in Chair and Vice Election will be conducted by ballot. The Chair of the Care Council will only cast a vote in the event of a tie.

C. No action will be deemed to have been taken by the Care Council unless duly voted upon and passed by the Care Council, or Standards and Issues Committee (SIOC).

VIII. PROCEDURES FOR COUNCIL MANDATED ACTIVITIES

* 1. **Needs Assessment**: The Part A Recipient is responsible for ensuring that an ongoing needs assessment process is implemented, which facilitates the establishment of priority health and support services to be funded under Part A and Part B. The Care Council, with support from the Care Council staff, is responsible to the Recipient for assisting in completing needs assessment activities and preparing needs assessment reports and documents. The needs assessment process should include, but is not limited to: an epidemiological overview, an assessment of service gaps, an analysis of all available HIV funding streams in the EMA, and an overview of the most recently available needs assessment survey data. Needs assessment reports and documents will be completed in accordance with Federal Grantor and Recipient requirements.
  2. **Establishment of the Health and Support Services Priorities**: The Care Council staff and the Care Council will, in close coordination with the Recipient, develop, publish, and update the Care Council’s yearly work plan, including a schedule of activities with all known decision points, timelines, and deadlines for accomplishing both mandated duties and Care Council goals and objectives. The work plan will include sufficient detail to track work and milestones, including establishing service priorities to allow the Recipient sufficient time to prepare and submit the Part A and Part B grant proposals (which must include the Care Council’s service priorities). To accomplish this, the Planning and Evaluation Committee will convene to review the needs assessment and make recommendations for priorities and the Resource Prioritization and Allocation Recommendations Committee (RPARC) will make allocation~~s~~ recommendations which are driven and justified by the needs assessment. These recommendations and the results of the needs assessment will be presented to the Care Council at a publicly announced meeting. The Care Council will vote on the recommendations at this meeting, or will elect to reconvene a maximum of two weeks later to make the final decisions. If the Committee recommendations are not accepted, the Care Council must also ensure that their decisions are driven and justified by the needs assessment. The Care Council will present to the Recipient the detailed list of priority services for the service area, with any allocation recommendations and specific recommendations for sub-priorities or special county-specific requirements.

In the case that the Recipient receives notification of award above level funding, RPARC will be convened in the same manner discussed above.

The Care Council’s work plan will also allow for sufficient lead time for the Recipient to accomplish the following:

1. To prepare and publish competitive procurement documents;

2. To establish the appropriate funding levels for each service priority in coordination with the Administrator and appropriate Care Council committees;

3. To prepare, publish, receive, and evaluate service provider funding applications; and

4. To negotiate and execute HIV service contracts with selected providers.

C. **Integrated Prevention and Care Plan**: The Care Council’s Planning and Evaluation Committee, working directly with the Care Council staff, will develop and update the Comprehensive Plan for the organization and delivery of health services. The Care Council will approve the Plan and any changes to it, and will ensure that the Plan includes all available HIV services within the total service area regardless of funding source.

D. **Assessment of Fund Allocations**: The Care Council, through its designated committee, working directly with the Care Council staff, will develop criteria for and prepare an assessment of the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the total service area.

IX. PART A GRIEVANCE PROCEDURES

The Care Council must develop procedures for addressing grievances with respect to Part A funding (i.e., against the Recipient and/or Care Council), including procedures for submitting grievances that cannot be resolved to binding arbitration.

Grievances that arise pertaining to matters of the Care Council or its bylaws should be addressed in writing first to the chair of the appropriate committee, if unresolved then to the Care Council Chair, thirdly to the Standards, Issues and Operations Committee with final appeal to the Care Council as a whole.

A. Processes which fall under the realm of these grievance procedures.

1. Deviations from an established written priority setting or resource allocation process (e.g., failure to follow established conflict of interest procedures).

2. Deviations from an established written process for any subsequent changes to priorities or allocations.

B. Description of processes listed.

1. The process of establishing priorities.

a. Needs assessment is completed.

b. A public meeting is held to review the components of the needs assessment.

c. The Care Council Planning and Evaluation Committee convenes to review the comprehensive needs assessment and makes prioritization recommendations based upon the needs assessment. (The needs assessment is an unbiased process. It is for this reason that any prioritization decisions must be based upon the data presented in the needs assessment.) RPARC will then make allocation recommendations which are driven and justified by the needs assessment process.

d. The RPARC meets with the full Council to present the recommendations. This meeting is publicly noticed. The Care Council may accept the RPARC recommendations at this meeting. If the Care Council does not accept the RPARC recommendations, they may vote to reconvene a maximum of two weeks later to vote.

e. The Care Council reconvenes a maximum of two weeks later to vote on the recommendations. This meeting is publicly noticed. If the Care Council does not agree on recommendations, which were presented two weeks earlier, resolution must be achieved at that meeting.

f. Once the priorities and allocations are agreed upon by the Care Council, they are transmitted to the Recipient for use in the Request for Applications and contracting process.

2. Allocating funds to those priorities.

a. The Care Council will make every effort to distribute the percentage of funds according to the percentage of AIDS and/or HIV cases in the respective county. (That is, if Hillsborough County has 54% of the reported AIDS cases, then the Care Council will make every effort to allocate 54% of the funds to that county.) If the Care Council does not allocate funds according to the respective percentages, they must specify in the minutes of the meeting why they did not. In addition, the decision must be based upon the needs assessment. (For example, a rural county receiving a higher proportion of funds because the needs assessment indicates that a new service must be implemented there.)

b. The Care Council will allocate percentages of funds to services based upon the last year’s allocation and the needs assessment’s indication of increased/ decreased need in that area (i.e., if transportation was allocated 5% of the funds last year, and components of the needs assessment indicate a greatly increased need for transportation from last year’s needs assessment, then the allocation for transportation may be increased). The amount of increase/decrease will depend upon:

1. the percentage change in need, and the availability of other funding streams to fund that particular service.

C. Who may file a grievance against the Care Council?

Individuals or entities directly affected by the outcome of a decision related to Part A funding must be eligible to bring a grievance. Directly affected parties will include:

1. Providers eligible to receive Ryan White Part A funding;

2. Patient groups/PLWH coalitions and caucuses;

3. Care Council members;

4. Recipient.

D. Grievance Process

The Grievance process may be requested from the Ryan White Administrator.

X. Bylaw Revisions

A. These Bylaws may be amended at any regular or special meeting of the Care Council.

B. Written notice of the proposed Bylaw changes shall be emailed to each voting member at least thirty days prior to the date of the meeting at which such discussion and voting will take place.

C. Bylaw changes require a quorum and two-thirds majority vote of the Care Council voting members present.

D. Bylaw changes shall be presented to the Care Council through the normal committee approval process.

XI. Emergency Protocol

Natural or man-made events may occur that constitute an emergency for residents of the EMA and TSA. Such events may impact the ability of the Care Council to meet and/or reach quorum and thus prevent the Care Council from conducting essential business. When such emergencies occur, the Care Council may invoke the following Emergency Protocol to assure that its partnership with the Recipient, Lead Agency, and clients, is intact and maintains essential services for people living with HIV in the EMA and TSA. For these purposes, an “Emergency” is one that is legally declared by the State of Florida or the Federal Government of the United States for the area covered by the EMA or TSA.

1. Members who have expressly stated that they have temporarily relocated and cannot attend meetings, or members who cannot be reached or fail to respond to attempts to reach them after ten business days will be considered displaced. Displaced Care Council members will automatically be granted a Leave of Absence. Leave of Absence is defined as the removal of the names of displaced members from the roll call to facilitate the establishment of quorum under emergency circumstances. Such absences will not count toward absence limits and displaced members will have full voting membership restored when they have returned to the area and are able to attend meetings again.
2. If the emergency occurs at a time that delays the appointment of new members or the term renewal of existing members, the Care Council may, by majority vote, extend the terms of persons who were members at the time of the emergency, but would have ceased to be members according to the Care Council’s term limitations. This provision is both to establish continuity of operations and to compensate for the delay in appointing new members.
3. If the emergency occurs at a time that delays the election of the Chair/Vice Chair, the Care Council may, by majority vote, extend the terms of the current Chair/Vice Chair at the time of the emergency.
4. The Emergency Protocol is time-limited to three months, but may be reinstated.

XII. History

Presented to the Care Council membership on September 1, 1999, at which time these bylaws were passed by vote of the Care Council, at which a quorum was present.

Amended 4/5/2000 Amended 7/3/2002 Amended 7/5/2006 Amended 1/5/2011

Amended 2/7/2001 Amended 9/4/2002 Amended 6/6/2007 Amended 2/2/2011

Amended 4/4/2001 Amended 3/5/2003 Amended 12/5/2007 Amended 6/6/2012

Amended 9/5/2001 Amended 3/2/2005 Amended 12/3/2008 Amended 11/7/2012

Amended 2/6/2002 Amended 6/1/2005 Amended 5/6/2009 Amended 11/5/2014

Amended 5/1/2002 Amended 3/1/2006 Amended 9/2/2009 Amended 9/2/2015

Amended 2/1/2017 Amended 10/3/18 Amended 11/6/19 Amended 2/1/2023

DEFINITION OF TERMS

The following definitions shall have the ascribed meaning when used in these Bylaws, except to the extent that the context clearly requires and indicates otherwise.

**AIDS SERVICE ORGANIZATIONS (ASO):** An organization which provides medical or support services primarily or exclusively to populations living with and affected by HIV.

**COMMUNITY BASED ORGANIZATION (CBO):** An organization which provides services to locally-defined populations, which may or may not include populations living with or affected by HIV.

**CONSORTIUM:** A regional or statewide planning entity established by State recipients under Part B of the Ryan White HIV/AIDS Program to plan for Part B services.

**ELIGIBLE METROPOLITAN AREA (EMA):** The geographic area eligible to receive Part A funds. The office of Management and Budget (OMB) defines metropolitan areas based on Census Bureau data. AIDS cases reported to the Centers of Disease Control and Prevention (CDC) determines eligibility. Some EMAs include just one city and others are composed of several cities and/or counties. Some EMAs extend over more than one state. The Tampa-St. Petersburg EMA consists of Pinellas, Hillsborough, Pasco, and Hernando Counties.

**LEAD AGENCY/ PART B:** The agency responsible for contract administration; also called Part B. Assists States and Territories in improving the quality, availability and organization of health care and support services for individuals and families with HIV,and provides access to needed pharmaceuticals through the AIDS Drug Assistance Program (ADAP).

**PART A**: Provides emergency relief to metropolitan areas that are disproportionately affected by HIV/AIDS.

**PLWH:** People Living with HIV

**TOTAL SERVICE AREA (TSA):** Used to describe the eight counties serviced under the West Central Florida Ryan White Care Council: Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas, & Polk.